RESPONSES TO REQUEST FOR STAKEHOLDER COMMENT
Evaluation and Design of an Insurance Exchange in Connecticut
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A. Establish a Responsive and Efficient Structure

1. Should Connecticut consider joining a multi-state Exchange? Under a regional Exchange, would Connecticut benefit most from a separate or merged risk pool?

Connecticut is participating in the New England Consortium to take advantage of shared assets for the purposes of developing an information technology structure which will be "exportable" to different state Exchanges. This makes good sense. The NEC allows the participating states to leverage the $35 million grant given to Massachusetts for developing Exchange information technology, providing an immediate economic benefit to each state. The NEC does not establish a regional health insurance Exchange.

A regional approach to health insurance Exchange operations would be a much more complex challenge. States have different health insurance laws and approaches to regulating the insurance industry. Key issues would be:

- How would a multi-state Exchange be controlled? Which state laws and regulations would apply? Which state laws and regulations would control when there are conflicts?
- Which regulator would have the ultimate authority? Would there be hybrid regulatory schemes which could result in issues with continuity of coverage and possibly add to the cost structure of the Exchange?
- Complexity, and thereby costs, would likely increase.
- How would multi-state rating systems be addressed?
- How would Connecticut consumers be protected if Connecticut did not control the Exchange?
- How would costs be controlled in a multi-regulator environment?
- Once a state participates in a multi-state Exchange, could it ever separate from the multi-state Exchange if its approach did not provide sufficient value to the state, or if it conflicted with the state's constitution, statutes, court decisions, goals, or obligations?

It is unclear how a multi-state Exchange would provide better health insurance coverage for Connecticut citizens.

Finally, a multi-state Exchange would seem to conflict with the Governor's expressed concerns about public entities unaccountable to the state's citizens and taxpayers.

2. **Should Connecticut administer the Exchanges for the individual and small group markets separately or jointly? If jointly, should Connecticut maintain separate risk pools for the two Exchanges, or merge the risk pools?**

Answering this question requires a thorough understanding of and appreciation for the current structure and regulatory requirements of each of these markets in Connecticut. The following issues would need to be considered:

- Today, each market is a unique pool governed by different laws and regulations.
- In the individual market, the issuing carrier assumes all the risk of the insureds. Applicants are medically underwritten. The experience of a block of business is used to determine rating actions. No reinsurance mechanism is provided by the state.
- In the small group market, including one-employee groups, coverage is guaranteed issue with no medical underwriting. Poor risks may be reinsured through CSEHRP, a state-endorsed mechanism for spreading the cost of high-risk insureds among participating carriers.

3. **Should Connecticut open the Exchange to businesses with 2-100 employees in 2014, or should it allow businesses with 2-50 employees in 2014 and increase participation to businesses with 51-100 employees in 2016?**

Current Connecticut law defines a "small employer" as an employer with 1-50 eligible employees. These are the groups that are supported by the CSEHRP pool. Expanding this pool to employers with 100 eligible employees would require statutory changes, new regulations, and changes in reinsurance risk characteristics. Today, the 50-99 employee market is partially experience rated, which results in credibility adjustments for the group's experience. Expanding the small group pool to include these larger employers would change the insurance rating system for these employers. Some of these employers may see lower rates as a result, but others will experience higher rates as part of an expanded pool.

4. **Should Connecticut seek to expand access to businesses with more than 100 employees in 2017, with HHS approval?**

It is unclear what the benefit would be of selling Exchange coverage to employers with 100 or more employees. The risk pool for these employers would remain separate from the risk pool for small employers. It is unclear how large employer coverage would be rated in the Exchange compared to outside the Exchange. Larger employers are used to greater flexibility in plan design options, so plan designs would likely need to differ for this market. It is not clear that there would be administrative advantages to including another different demographic in the Exchange. An additional risk with allowing larger groups into the Exchange is that larger groups can choose to self-fund their plans. It is therefore likely that only larger employers whose self-funded claims exceeded their Exchange premium would join the Exchange, thereby deteriorating the experience of the Exchange pool.

B. Address Adverse Selection and the External Market

1. Should Connecticut allow a dual market, a hybrid market, or should it require that all individual insurance be sold through the Exchange? Under a dual market scenario, what additional rules should Connecticut establish to prevent insurers from discouraging participation in the Exchange? What hybrid models might Connecticut consider, and what characteristics do they offer that would benefit Connecticut?

A dual market approach would allow Connecticut residents the best range of choice and availability possible when purchasing health insurance. However, under a dual market scenario, the rules must address the possibility of out-of-state insurers "gaming" the market by offering products exclusively outside the Exchange, with benefits, plan designs, and rating methodologies that allow the out-of-state carriers to selectively target better risks, without regard to Exchange rules.

2. Are there any additional mechanisms to mitigate adverse selection that Connecticut should consider implementing as part of the Exchange?

Under the Patient Protection and Affordable Care Act (PPACA), federal regulations will be issued later this year addressing reinsurance and risk adjustment programs both inside and outside Exchanges. Connecticut could explore the possibility of CSEHRP serving as the reinsurance program for the small group market, and possibly for the individual market as well, either with separate or combined reinsurance pools. The state could then study whether or not a risk adjustment program would be necessary.

3. How should the temporary reinsurance program be approached in Connecticut? What issues should Connecticut be aware of in establishing these mechanisms?

Connecticut should consider the experience and availability of CSEHRP when designing a reinsurance mechanism. The major issues to consider in designing a reinsurance pool include: how to determine the reinsurance premiums, and how to assess the reinsurance losses in a way that will encourage carriers to enter and stay in the market.

C. Simplify Health Insurance Purchase

1. What issues should Connecticut consider in establishing a Navigator program?

The intent of the Navigator program is for Navigators to serve as another channel by which consumers may access their Exchange coverage options. Specific standards should apply.

a. Entities applying to be a Navigator should demonstrate a substantial amount of experience, including seasoned staff, in performing outreach and education about important health insurance issues.

b. Navigators should have the skills and knowledge to reach the uninsured populations and populations not typically reached by traditional distribution channels.
c. Navigators should demonstrate working knowledge of health plan operations, including enrollment functions.
d. To ensure they will remain impartial with respect to consumer choices, Navigators should not be able to require fees from health plans or be reimbursed by providers or consumers for their services.
e. Navigators should be impartial as to health plans and providers.

Navigators can provide value by utilizing existing resources and points of contact as a means of connecting with consumers, especially hard-to-reach consumers, minimizing the additional cost burden placed on the state. Navigators may be well-positioned to help consumers enter the appropriate information into the initial standardized application required by PPACA -- a labor-intensive process where Navigators could be extremely helpful. As a consumer protection, to the extent a Navigator is performing functions which require a producer's license in the State of Connecticut, Navigators should be licensed as producers and regulated by the Connecticut Insurance Department.

2. What issues should Connecticut consider regarding the role of insurance brokers and agents?

Independent insurance brokers and agents (producers) perform a variety of sophisticated functions that help Connecticut consumers with choosing and using health insurance coverage, not only at the time of sale and renewal, but throughout the plan year. Licensed independent producers, for example:

- Maintain current knowledge of the competitive marketplace
  - Stay current with Connecticut legislative issues
  - Have knowledge of current trends in products, such as HSAs and their tax benefits for employers and employees, and introduce and maintain relationships with TPAs for funding administration
  - Stay current with <u>all</u> carrier products, networks, underwriting rules, processes, etc. – a time-consuming task
  - Maintain supplies for enrollment and have knowledge about enrollment rules for <u>all</u> carriers
  - Maintain basic knowledge of tax benefits and consequences for employers and employees with FSAs, HRAs, HSAs, etc.

- Provide consultative services to groups of all sizes
  - Fact-find with clients to determine needs
  - Recommend best products for clients
  - Compare prices and plans among carriers

- Conduct multiple face-to-face presentations to decision-makers, benefits administrators, etc., until benefit decisions are reached

- Conduct multiple open enrollment meetings with employees to explain benefits as well as funding options for consumer-directed plans
    - Address specific benefit questions – what is covered and how
    - Address transition of care questions
    - Address deductible credits or carryover issues and concerns

- Provide ongoing service throughout the plan year
    - Help resolve claim questions and issues
    - Answer questions regarding coverage, billing, enrollment, etc.
    - Act as a resource for COBRA administration (small group)
    - Counsel employees as they age into Medicare, as dependents age off of group plans, at the time of a disability, when a child is born, at termination of employment, etc.

- Facilitates the annual plan renewal
    - Shop the market for competitive plans and rates
    - Present findings to decision-maker
    - Conduct open enrollment meetings, comparing old to new plans, identifying changes for employees
    - Address questions and concerns about new benefits
    - Meet one-on-one with employees, especially if introducing a consumer-directed plan

- Maintain an ongoing relationship with the employer
    - Conduct regular outreach, personal visits, etc., to remain visible to the employer
    - Take calls from employees with service questions or issues
    - Work with carriers to resolve any problems

D. Increase Access to and Portability of High Quality Health Insurance

1. **Should Connecticut allow any plan that meets Qualified Health Plan standards to be available in the Exchange, or should Connecticut establish additional requirements? If additional requirements, what would you recommend? What would be the impact of those requirements**?

All health plans that meet the requirements to be a Qualified Health Plan should be allowed to offer coverage through the Exchange. Enrollee choice is best facilitated by having a range of carrier options from which to choose coverage. Choice encourages competition by allowing Exchange enrollees meaningful options for changing coverage if they are not satisfied with their current plan choice. The existing requirements in PPACA for designation as a Qualified Health Plan are already robust and include standards health plans must meet regarding:

- Marketing practices
- Network adequacy (ensuring a wide choice of providers)
- Accreditation (e.g., clinical quality measures such as HEDIS and CAHPS survey and patient information programs)

- Quality improvement strategies that incorporate a payment structure that provides increased reimbursement and other incentives
- Uniform enrollment forms
- Standardized format for presenting plan options
- Quality measures for health performance endorsed under the federal Public Health Service Act

Health plans must also meet Connecticut Insurance Department requirements for a certificate of authority and appropriate licenses to do business (e.g., assume risk, perform utilization review activities). Requirements include: meeting market conduct and financial adequacy standards enforced by the Insurance Department, complying with all state insurance laws and regulations, and meeting financial and solvency standards. Requirements in addition to these and those listed above in PPACA would serve as a barrier to plan participation and robust competition and could increase administrative costs with questionable added benefit.

2. **Should Connecticut consider establishing the Basic Health Program? What would the Basic Health Program offer as a tool to facilitate continuity of coverage and care?**
3. **How would the Basic Health Program impact other related programs in Connecticut?**

Under PPACA, states may contract with "standard health plans" to provide a Basic Health Program that covers at least essential benefits to individuals between 133% - 200% of the Federal Poverty Line. This is the population which is not eligible for Medicaid and is eligible for subsidies to purchase health insurance coverage through the Exchange. If a state provides coverage through a Basic Health Program, the state receives the subsidy money the individual would have received to purchase coverage through the Exchange. Premiums for the Basic Health Program may not exceed the amount the individual would have paid in the Exchange. Cost sharing for the Basic Health Program may not exceed specific cost-sharing levels set for certain Exchange coverage. The Basic Health Program may not be open to the broader insurance market, and Basic Health Program eligible individuals may not purchase coverage through the Exchange. States setting up a Basic Health Program must seek participation by multiple health plans to allow enrollees choice. The Basic Health Program is also expected to provide innovative features, such as care coordination, case management, incentives for preventive care, patient/provider relationship standards, care management, and quality performance measures for practitioners. Coverage provided must be at least the minimum essential coverage to be defined by federal regulation.

If Connecticut were to explore the option of establishing a Basic Health Program, it should consider the continuity of care standards required of health plans seeking accreditation from the National Committee on Quality Assurance. These standards require accredited health plans to:

- Monitor the continuity and coordination of care between practitioners (e.g., between primary care physicians and specialists).
- Measure performance in this area and make improvements when needed.
- Notify members affected by the termination of a primary care practitioner.
- Monitor the coordination of general medical care and behavioral health care.

- Collaborate with their contracted behavioral health specialists in collecting and analyzing data and taking action to improve the coordination of behavioral health with general medical care.

4. How can Connecticut structure its Exchanges to maximize continuity of coverage and seamless transition between public and private coverage? (E.g. as a person moves from Medicaid, subsidized and non-subsidized markets)

We recommend that the Exchange accept accreditation by the National Committee on Quality Assurance as evidence that a health plan has in place robust continuity of care practices. NCQA-accredited health plans must:

- Monitor the continuity and coordination of care between practitioners (e.g., between primary care physicians and specialists).
- Measure performance in this area and make improvements when needed.
- Notify members affected by the termination of a primary care practitioner.
- Monitor the coordination of general medical care and behavioral health care.
- Collaborate with their contracted behavioral health specialists in collecting and analyzing data and taking action to improve the coordination of behavioral health with general medical care.

E. Ensure Greater Accountability and Transparency

1. What information should Connecticut include for outreach to most effectively engage consumers? How should the information be presented?

Consumer outreach should be implemented through media appropriate to and chosen by the consumers who are the Exchange's target audience. Cultural, linguistic, and diversity issues must be addressed in outreach materials. Information disseminated should be simple, complete, and appropriate to achieving its intended goal.

2. How should Connecticut ensure ongoing feedback and input about accountability, operational issues, and suggested improvements?

Regarding health plans, carriers have a strong consumer protection system currently in place through the Connecticut Insurance Department. This is an effective and efficient system for ensuring health plan accountability in Connecticut. The Exchange should work through the Insurance Department to leverage the capabilities of the current system when seeking information about health plans.

Regarding the Exchange itself, the Exchange should be set up as a state agency to ensure accountability to the Governor and the citizens and taxpayers of Connecticut. To ensure accountability and transparency, the Exchange must regularly publish information about the following:

- The activities undertaken by the Exchange.
- The total number of carriers participating in the Exchange for the current calendar year.

- The total number of carriers expected to be participating in the Exchange for the upcoming calendar year.
- Audited financial reports, certified by the top executive of the Exchange, as of the December 31 of the year preceding.
- The average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an internet website. This information must be updated at least annually. This information must include monies lost to waste, fraud and abuse.
- The amount of monies collected from fees charged to insurers, including filing fees, any other fees, and any grant monies received from the federal government or other entities outside of state government, on an internet website. This information must be updated at least annually.
- An accurate accounting of all activities, receipts and expenditures.

3. What information, beyond that required under the ACA and implementing regulations, should Connecticut require of plans? How much of this information should be shared with consumers accessing the Exchange?

The information and reporting requirements for health plans under PPACA are extensive and will provide consumers and regulators with comprehensive, useful data on health coverage options available to consumers. Additional reporting would increase plan expenses and provide "diminished returns": for plans since they would need to devote more resources to potentially burdensome and redundant requirements; for regulators who will need to weed through more and more documents for desired information; and for consumers who may suffer from confusion and "information overload" in an already complex environment. All reporting requirements should be focused on providing information of high value in the simplest, most understandable, and least costly format possible.

F. Self-Sustaining Financing

1. How should the Exchange's operations be financed beginning in 2015?
2. How might the state's financing strategies encourage or discourage participation in the Exchange; affect the reputation of the Exchange; and affect accountability, transparency, and cost-effectiveness?

To maximize objectivity in the Exchange's operations, the state should consider enacting a broad funding mechanism to include fees and assessments on non-insurer stakeholders, products or services, such as on tobacco products, alcoholic beverages, indoor tanning services, foods and beverages with low nutritional value ("junk foods"), manufacturers of pharmaceuticals and medical devices or cosmetic procedures. Broad-based funding would also help keep Exchange costs out of Connecticut health insurance plans. Fees and assessments on insurers are inevitably passed along to insurance customers.

When considering how to fund the Exchange, the state must consider the following issues:

- Any assessments or fees charged must be limited to the minimum amount necessary to pay for the administrative costs and expenses incurred in the operation of the Exchange, after consideration of other available funding.
- If the state should decide to levy assessments or fees on insurers, any such assessments or fees charged to carriers should not include any amount based on HIPAA-excepted benefit plans or premiums for HIPAA-excepted benefit plans.
- Services performed by the Exchange on behalf of other state or federal programs must not be funded with assessments or user fees collected from health insurers.
- Any funds unspent by the Exchange must be used for future state operation of the Exchange or returned to health carriers as a credit if the state charges fees to carriers.
- Taxes, fees or assessments on insurers used to finance the Exchange must be clearly disclosed by the Exchange as such, must be considered a state tax or assessment as defined in section 2718(a) of the Public Health Service Act and its implementing regulations, and therefore must be excluded from health plan administrative costs for the purpose of calculating medical loss ratios or rebates.

3. What issues should be considered regarding state requirements for additional benefits above the minimum essential benefits? What funding sources should be considered for the cost of additional benefits?

If the state chooses to require Exchange plans to cover benefits above the "minimum essential benefits" that will be set by federal regulation, state taxpayers will be required to fund the cost of those extra benefits for Exchange enrollees receiving federal subsidies. Under PPACA, neither health plans nor Exchange enrollees may be charged for these costs. Given Connecticut's current budget environment, funding for extra benefits would be very difficult to secure. Further, enrollees purchasing Exchange coverage without subsidies should be able to enjoy lower premium costs by choosing more affordable essential benefit plans and not be forced to pay for benefits they may not want.

G. Under the ACA, an Exchange is responsible for performing a specified list of functions. However, many decisions are left to the states.

1. Beyond the Exchange's minimum requirements, are there additional functions that should be considered for Connecticut's Exchange? Why?

Given the complexity of functions already required of Exchanges, the Connecticut Exchange should focus on achieving the goals necessary for certification and operation of an Exchange as directed by the Federal government. Additional functions would detract from these activities and potentially jeopardize federal funding and risk depriving Connecticut consumers of an Exchange that will best meet their needs.

2. **Are there advantages to limiting the number of plans offered in the Exchange, or is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?**

The Exchange will be a stronger marketplace for allowing all qualified plans to participate. Given that the purpose of the Exchange is to facilitate consumer choice, it makes sense to give consumers as much flexibility as possible by maximizing the choices available to them. Standards for reaching Qualified Health Plan status under PPACA are quite high and will themselves ensure the quality of participating Exchange health plans. Artificial or political limitations on plan participation would harm consumers by, among other things, restricting choice.

3. **Should Connecticut consider setting any conditions for employer participation in the small group exchange (e.g. minimum percent of employees participating, minimum employer contribution, limits in the range of product benefit values that may be selected by employees, etc.)?**

The Exchange should set a common approach for small employers seeking to purchase coverage through the Exchange in areas such as the definition of eligible employees who may enroll for coverage, eligible group size, participation requirements and employer contributions. Requirements for any regulated areas should be set with due consideration to the corresponding norms in the existing market.

4. **What are some of the initiatives that could maximize flexibility and offer a value for small business employers to utilize the Exchange?**

Small employers purchasing coverage through the Exchange will be eligible for tax credits that are not available to them outside of the Exchange. These tax credits alone will drive small employer traffic to the Exchange. Additional initiatives could consume valuable Exchange resources without a corresponding increase in small employer participation. The Exchange will provide value to participants if it functions effectively in a cost-efficient manner. If the Exchange fails to meet these goals, people will go elsewhere for health coverage. Consequently, the focus of the Exchange should be on implementing the required elements of the Exchange with an emphasis on high-quality, low-cost service.

5. **What should be the role of the Exchange in premium collection and billing?**

To ensure smooth functioning of the Exchange from the employer and enrollee perspectives, the Exchange will need to act as the "back office" for premium billing, collection and remittance to the participating carriers. The administrative structure is particularly complex in the group market, where employees in a group are allowed to choose among any of the carriers being offered. The Exchange will therefore need to split the premium received from employers among different carriers, accounting for each enrollee's carrier and particular plan choices. Costs would rise if participating health plans were required to send out small, fragmented bills to participating employers. Consolidation is also required to make billing and payment simple for employer and insurer participants. If billing problems are common and difficult to resolve, people will go

elsewhere for health coverage. The Exchange must rapidly acquire the skills needed for it to act as the consolidator in this split-billing insurance environment. The Massachusetts Connector, for example, hired a private contractor to perform these functions with participating carriers.

The Exchange will also need to have procedures for: delinquent premium collections; termination for non-payment (group and member-specific); accounts receivable; COBRA administration; payment methodologies; financial administration for any consumer-directed plans; and reconciliations of all receipts and payments with all parties involved.

6. What are all the different data collection and reporting mechanisms that are necessary to operate a transparent and accountable Exchange?

At a high level, the Exchange will need to collect and disseminate a great deal of information to successfully accomplish transparent and accountable operations. Timely collection and distribution of data should include but not be limited to:

- Membership demographics.
- Plan selection options.
- Claim and utilization information.
- Premium billing.
- Accounts receivable and outstanding debt.
- Details on any assessments or fees which are collected to fund Exchange operations.
- Migration reports.
- Overall experience of the Exchange and the carriers participating in it.
- Periodic reports about the activities undertaken by the Exchange.
- The total number of carriers participating in the Exchange for the current calendar year.
- The total number of carriers expected to be participating in the Exchange for the upcoming calendar year.
- Audited financial reports, certified by the top executive of the Exchange, as of the December 31 of the year preceding.
- The average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an internet website. This information must be updated at least annually. This information must include monies lost to waste, fraud and abuse.
- The amount of monies collected from fees charged to insurers, including filing fees, any other fees, and any grant monies received from the federal government or other entities outside of state government, on an internet website. This information must be updated at least annually.
- An accurate accounting of all activities, receipts and expenditures.
- All information required to satisfy internal and external audit activities.